Developing Peer Roles and Training in the UK
(with a focus on mainstream, statutory NHS services)

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Peer Support in the UK

- Alleged Lunatic Friend (ALF) 1860s
- Peer support networks in service user led/self-help groups
- Peer workers in addictions services – especially addictions rehab (often in non-statutory sector)
- Peer workers in non-statutory services
- (A very few) peer run services

Including the expertise of lived experience in mainstream, statutory mental health services has been much slower to develop …
Structural barriers to including the expertise of lived experience in mainstream, statutory services

- Legacy of the ‘Clothier Report’ – ‘2 year rule’

- Highly professionalised services – the main professions (psychiatry, nursing, occupational therapy, clinical psychology, social work) have ‘cornered the market’:
  - Rules within services restricting what non-professionals can do e.g. care coordinators have to be trained professionals
  - Pay structures protect the position of professionals – the ‘Band 5’ bar (but boundaries are being tested in some places)
  - Perform both specialist professional assessments and interventions and more general support. Both are important BUT
    - Most of what services provide is not specialist, professional assessment and treatment/therapy
    - Using professionals to perform non-professional roles is costly, it desskills people and professionals do not always have the necessary skills ...
Attitudinal barriers to including the expertise of lived experience in mainstream, statutory services

- Boundaries between ‘us’ and ‘them’ remain
- Disclosure actively discouraged among professional staff
- Huge scepticism about whether ‘they’ will be up to the job:
  - ‘It needs professional training, they don’t have the skills, people with mental, heath conditions not safe in untrained hands’
  - ‘What happens if they break down at work?’
  - ‘What about confidentiality?’
  - ‘What about transference - will they really be objective?’
  - ‘They won’t be able to cope with the stress of the job.’
  - ‘Won’t they be dangerous to the vulnerable people we serve?’
  - ‘Won’t they be unreliable - off sick all the time?’
  - ‘Mentally ill people will be taking our jobs.’
  - ‘We won’t be able to tell jokes in staff team meetings any more.’
Including the expertise of ‘lived experience’ in the mental health workforce

1. Employing people with mental health problems in existing positions in the workforce

2. Creating new roles and relationships - employing ‘Peer Workers’
Employing people with mental health problems in existing positions in the workforce

Developed from SW London User Employment Programme (established in 1995)

• Designed to increase access to employment in mental health services for people who have lived experience: by 2005 25% of employees had lived experience … more in most senior positions (33%)
  – Supported employment programme
  – Charter for the employment of people with mental health conditions

• Initially enormous objections
  – Nursing professional body – it will lower the standard of services
  – Social work press – what about criminal records – it will be unsafe

• Eventually much government support – replicated in many places

• 2009 national ‘Open Your Mind’ campaign from NHS Employers
BUT...

Employing people with mental health problems in existing positions is important, but it is not enough

A nurse (or a psychologist, or a social worker or a doctor, or an occupational therapist) with mental health problems is still a nurse (or a psychologist, or a social worker or a doctor, or an occupational therapist)

They are employed as professionals rather than peers ... And their relationship with the people who use services is that of a professional

Traditional power, hierarchy, claims to special knowledge about others etc. remain
2. Creating new roles and relationships - employing ‘Peer Workers’

Creating new roles and relationships where people can learn and grow as equals drawing on each other’s expertise and experience

- Employing people whose core expertise is lived experience
- Peer support means moving beyond traditional expert/patient roles
- Founded on mutuality: shared responsibility, shared journey, reciprocity ... with people who are a few steps on in a similar journey
Different sorts of peer worker roles

• Peer support workers/specialists in clinical teams
  – important in fostering the recovery of those who they serve and changing culture of team  BUT
  – mainly in lower ‘unqualified’ grades therefore expertise not seen as equal to that of traditional professionals

  Other types of roles are also important:

• Peer trainers
  – co-producing and co-delivering training in Recovery Colleges/Education Centres for people using services and mental health workers
  – fundamentally changes power relationships – moving above unqualified grades

• Peer Governors, members of strategic committees, staff selection etc.
  – Moving from ‘user involvement’ to genuine co-production in the design and delivery of services

• Peer researchers
  – Evaluating effectiveness of services in peer terms
Peer support workers, personalisation, self-directed support and personal budgets

Peer support workers providing brokerage and assistance with support planning?

Purchasing peer support as part of support plan?

Not either/or but all!

Valuing the expertise of lived experience in people in traditional professional and managerial positions

Peer Support Workers
Peer Trainers
Peer Governors
Peer Researchers ….

Need variety of ways of making the expertise of lived experience available to people using, providing, commissioning and evaluating services
Different ways of introducing peers workers in statutory services:

- **New peer positions created within statutory services** – same terms and conditions as everyone else
  
  A core part of services – but may be more difficult to remain ‘peer’ without effective peer supervision, support and management

- **Peers employed on a casual ‘user involvement’ or ‘bank’ basis**
  
  Easier to establish but remain marginal, non-core and employees do not enjoy NHS terms and conditions (pensions, sick leave etc.)

- **Peer workers employed by non-statutory, peer-led organisations working into statutory services**
  
  Supervised and employed by peers therefore easier to remain ‘peer’ but not a core part of service and terms and conditions often less advantageous
Different ways of introducing peers workers in statutory services:

• **Peer workers providing peer support in statutory service on a voluntary basis**
  May enable a broader range of people to provide peer support - but not a core part of service and expertise not valued through payment

• **Contracting out parts of service to non-statutory, peer-led, peer-provided services e.g. Leeds Crisis House**
  Genuinely peer service, consistent with policy direction of ‘Opening Up Public Services’ – increasing the range of providers - but may remain marginal to core NHS services and therefore less able to challenge philosophy and practice of statutory services … and easier to cut in hard economic times and often very small scale
Training is central....

Preparatory training:

- Introduction to ideas about recovery
- WRAP/Planning your own recovery
- Telling your story

Core Peer Worker Training

Training in different branches of Peer Work:

- Peer Support Worker
- Peer Trainer
- Peer Researcher
- Peer Governor/members of committees and working parties

Preparation for existing staff where peer support workers are to be introduced
Delivering training …

Capacity to deliver training is likely to become a limiting factor in developing Peer Workers in statutory services:

• Buying training in from abroad (Recovery Innovations) or from UK non-statutory sector

• Creating training tailored to UK statutory setting

• Providing preparatory and core training, and training in different branches of peer work, as part of Recovery College/Education Centre

• Creating nationally accredited training that is recognised across services and accredited trainers

• Registration of Peer Workers with Health Professions Council
Resolving employment issues ...

• On-going supervision and support – who should do this before we have a cadre of peer support workers who have developed the skills? Maybe train people with both lived and professional experience

• Employment support as well as peer supervision and management

• Occupational health and CRB issues

• Creating opportunities for career progression

• Recognising the expertise of lived experience in NHS pay scales – breaking into band 5 and above

• Risk of peer workers ‘going native’, used to enforce compliance, become no more than ‘an extra pair of hands’
Peer Workers are central initiatives to create statutory NHS services that promote recovery ... 

but alone they cannot create services that genuinely promote the recovery of those whom they serve 

Changing the nature of the NHS work-force must occur in the context of a fundamental transformation of services ....
• Changing the relationship between services and those whom they service
  – ‘on tap’ not ‘on top’
  – moving from ‘experts fixing people’ to supporting self-management and self-direction … education as an overarching paradigm rather than therapy
  – the ways in which we approach risk and safety

• Changing the relationship between services and the communities they serve
  – re-creating communities that can accommodate human distress/disturbance –
  – enabling people with mental health challenges to participate as equal citizens and enjoy the rights and opportunities that all citizens should expect

• Recognising that statutory services are not the only provider of mental health services …

  the increasing importance of peer-led, non-statutory services in offering peer support in an era where there is a desire to increase the range of NHS providers